STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
			A. BUILDIN B. WING	U		03/21/2	011
				LDEET V	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			AST MCGALLIARD ROAD		
LYND HO	NICE				E, IN47303		
			IV	IONCIE	_, 11147 303		
(X4) ID		STATEMENT OF DEFICIENCIES	II	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
R0000							
	This visit was fo	or a State Licensure	R000	n			
		n a State Electistic	Room	٠			
	Survey.						
	Survey dates: M	farch, 16, 17, 21, 2011.					
	Facility number:	: 004428					
	Provider number						
	AIM number: N						
	7 HIVI HUMOOL. 1V						
	Survey team:						
	Delinda Easterly, RN TC						
	Ginger McName						
	Betty Retherford						
	Karen Lewis, Ri						
	Kaieli Lewis, Ki	N					
	Census bed type	:					
	Residential: 45						
	Total: 45						
	101a1. 43						
	Census payor ty	ne·					
	Other: 45	P • •					
	Other. 43						
	Sample: 9						
	•						
	These state findi	_					
	accordance with	410 IAC 16.2.					
		completed on March 24,					
	2011 by Bev Fau	ulkner, RN					
R0036		ust immediately consult the					
	resident 's physic	cian and the resident 's legal					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FIRH11

Facility ID: 004428

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE representative when the facility has noticed: (1) a significant decline in the resident 's physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. What corrective action(s) will R0036 04/30/2011 Based on record review and interview, the be accomplished for those facility failed to ensure the physician was residents found to have been notified when blood glucose levels were affected by this deficient below the ordered parameters and when practice? No other residents significant weight changes were were found to be affected. Resident #1 had his medical documented for 1 of 9 residents reviewed condition reviewed regarding for physician notification in a sample of 9. weight loss by the licensed [Resident #5] medical professional with no new order obtained. The licensed Findings include: medical professional was also notified of blood glucose levels found to be under the established Resident #5's clinical record was reviewed parameters. How the facility on 3/16/11 at 3:00 p.m. The resident's will identify other residents diagnoses included, but was not limited to having the potential to be affected by the same deficient diabetes mellitus and CHF [congestive practice and what corrective heart failure.] action will be taken? No other residents were found to be The resident's current January, 2011, affected. The primary care Physician Recapitulation Orders were physician has established notification parameters regarding signed, but not dated by the Nurse abnormal blood sugars and Practitioner. The resident had orders for possible interventions. What blood sugar checks every morning and measures will be put into place every evening before meals. There was or what systemic changes will the facility make to ensure that an order for Instaglucose paste [for low the deficient practice does not blood sugar] use as directed and to call recur? The Residence Director. the M.D. for blood sugars below 60. The Wellness Director, and staff were resident had an order to self administer 34 re-trained in regards to the units of Lantus Solostar insulin every notification policy and procedure

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
			B. WINC			03/21/2011
		<u> </u>	D. WINC		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	R			AST MCGALLIARD ROAD	
LYND HO	NISE				E, IN47303	
					L, 1147 303	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	morning at 8:00	a.m.			for Diabetic Monitoring, Chang	- 1
					of Condition, and Documentate The Wellness Director will be	iion.
	Review of the Ja	nuary, 2011, Medication			notified and provide instruction	n as
	Administration I	Record [MAR] indicated			to further action as deemed	11 43
		the following 8:00 a.m.			necessary. The Residence	
	blood sugars:	3			Director and/or Wellness Dire	ctor
	1/21/11 - 55				will review and ensure that	
					service notes are in place to	
	1/22/11 - 59				ensure continued compliance	
					when changes are present. H	
		ord lacked any indication			will the corrective action(s) with the corrective action (s) with the corrective action (s) will be monitored to ensure the corrective action (s) will be monitored to ensure the corrective action (s) will be monitored to ensure the corrective action (s) will be monitored to ensure the corrective action (s) will be monitored to ensure the correction (s) will be monitored to ensure the corr	wiii
	of the Doctor be	ing notified of the low			deficient practice will not rec	our
	blood sugars.				i.e., what quality assurance	Jui,
					program will be put into place	ce?
	Review of the Ja	nuary, 2011, MAR			The Residence Director,	
		tion of the Instaglucose			Wellness Director, and/or	
		red and indicated the			Designee will perform an ongo	oing
		administer the 34 units of			weekly review of reported	
		administer the 34 units of			condition changes, the	
	Lantus insulin.				Medication Administration Records and service notes to	
					ensure continued compliance	with
	During an interv	riew with the Director of			our policy and procedure	With
	Nursing on 3/17	/11 at 10:10 a.m., she			regarding residents experience	ing
	indicated the fac	ility performs the blood			a change of condition. Finding	
	sugar checks for	Resident #5 and observes			will be reviewed and corrected	1
	~	nistration by the resident.			through our QA process. The	
		e resident did self			Regional Director of Quality a	na
		sulin on 1/21/11 and			Care Management or the Regional Director of Operation	ns
		physician had not been			will review this process during	
	1	•			routine site visits at least mon	•
		esident's low blood sugars.			By what date will the system	- 1
		e resident had not			changes be completed?	
	received the Inst	aglucose.			Compliance Date: 4/30/11	
					R0036, R0090, R0091 Will the	e
	Review of the re	sident's weights indicated			Residence Director, the	
	the following:	-			Wellness director, and/ or	
	3/3/10 - 265 pou	ınds			designee complete weekly	
	200 pou				l .	

STATEMEN	l ´			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	IILDING COMPLETED		
			B. WIN			03/21/2011
			-		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2410 E	AST MCGALLIARD ROAD	
LYND HO	DUSE			1	E, IN47303	
		TATEMENT OF DEFICIENCIES		ID		(V5)
(X4) ID PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
1110		· · · · · · · · · · · · · · · · · · ·	+	1710	reviews on all residents with	
	7/10 - 268 pound				condition changes, all	
	10/8/10 - 246 poi				medication records, and all	
	11/12/10 - 220 pc				service notes? Will the QA	
	12/31/10 - 240 pc	ounds			process for reviewing and	
	1/3/11 - 231 pour	nds			correcting any findings	
	2/8/11 - 228 pour	nds			continue indefinitely? Pleas	e
	•				specify how often this QA	
	The weights were	e recorded in a "Vitals			monitoring will occur and for	I
	_	t of the book indicated			how long? What is the criter	
	the physician should be notified of the following weight changes:				for discontinuing if less than	
					six months? The Wellness	
					Director and/or Designee will complete 1 random weekly rev	/iew
	•	ght gain or loss in one			of residents experiencing a	//CW
	month.				change of condition for a perio	od
	Seven and one ha	alf percent weight gain or			of three months by reviewing t	
	loss in three mon	iths.			Medication Administration Rec	I
	Ten percent weig	tht gain or loss in six			and Service Notes. Findings w	
	months.				be reviewed after three month	I
					by the Residence Director and Wellness Director to determine	I
	The resident had	a 22 pound or eight			the need for ongoing monitoring	
		oss from 7/10 to 10/8/10.			by the QA process. Findings	' <sup>9</sup>
					suggestive of 100 %compliand	ce
		a 26 pound or ten and a			will result in no further monitor	ing
		ght loss from 10/8/10 to			from the Wellness Director or	
	11/12/10.				Designee unless otherwise	
	The resident had	a 20 pound or nine			deemed necessary.	
	percent weight ga	ain from 12/31/10 to				
	1/3/11.					
	Review of the cli	inical record lacked				
		physician being notified				
	of the weight cha					
	of the weight cha	inges.				
	   D	ta tata ata .				
	During an intervi					
		d the Director of Nursing				
	on 3/16/11 at 4:1	5 p.m., they indicated				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	<u>`</u>	TE SURVEY  IPLETED	
			A. BUILDING B. WING		<del></del> 03/21	03/21/2011	
NAME OF I	PROVIDER OR SUPPLIER		STREET 2410 E	ADDRESS, CITY, STATE, ZIP O AST MCGALLIARD RC E, IN47303			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	I	vare of the weight changes believe the resident had s.					
		iew with the Director of '11 at 1:30 p.m., she					
	_	ident was reweighed on					
		weight was 212 pounds.					
R0090	overall managemeresponsibilities of include, but are not (1) Informing the cocurrence that disafety, or health of unusual occurrence that disafety, or health of unusual occurrence telephone, follower a written report or electronic mail to twenty-four (24) hoccurrences include (A) epidemic outbout (B) poisonings; (C) fires; or (D) major accident If the division can be made to the enpublished by the cocurrence of the provision of moursing care or other equested by the representative.  (3) Obtaining direct admission of an in (18) years of age (4) Ensuring the face occurrence includes the company of the provision of an in (18) years of age (4) Ensuring the face occurrence includes the company of the provision of an in (18) years of age (4) Ensuring the face occurrence that disable to the control of the company of the control of the contro	ts. not be reached, a call shall nergency telephone number division. aging for or assisting with edical, dental, podiatry, or the health care services as resident or resident's legal ctor approval prior to the adividual under eighteen					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		03/21/2011	
		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		EAST MCGALLIARD ROAD		
LYND HO	DUSE		l l	IE, IN47303		
(X4) ID		STATEMENT OF DEFICIENCIES	ID ID		(V5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110	worked that indicate	,	1710		DATE	
	(A) employee's fu					
		urs worked during the past				
	twelve (12) month					
		sults of the most recent				
	•	the facility conducted by				
		any plan of correction in				
		et to the facility, and any eys. The results must be				
		nination in the facility in a				
		essible to residents and a				
	notice posted of t					
		ports of surveys conducted				
		each facility for a period of				
		making the reports				
		ection to any member of the				
	public upon reque		R0090	What corrective action(s) wi	II 04/30/2011	
		review and interview, the	K0090	be accomplished for those	04/30/2011	
		ensure the Administrator		residents found to have been		
		ed for health care services		affected by this deficient		
	related to the ad	ministration of insulin		practice? No other residents		
	coverage by lice	nsed nursing staff as		were found to be affected.		
	required by state	e regulations and facility		Resident # 28's medical cond		
	policy for 1 of 1	resident (Resident #28)		and blood sugars were review	/ed	
	residing in the fa	acility with orders for		by the licensed medical professional with new orders		
	_	ulin who did not self		obtained. The Residence Dire	ector	
		cations and failed to		and Wellness Director made		
		ng staff contacted the		arrangements to ensure insul	in	
		•		administration orders were		
	physician, administered medications as ordered, and monitored and assessed 1 of			covered in the event a license		
				nurse is not available. Reside		
	,	dent #5) reviewed for		#5 was assessed by the nurse practitioner. The Wellness	<b>"</b>	
		valuation of low blood		Director completed the		
	sugars in a samp	ole of 9.	1	Medication Self Administration	ո [	
			1	Assessment and a new order		
	Findings include	e:		obtained. How the facility w		
			1	identify other residents havi	-	
	1.) During the i	nitial walk- thru tour of		the potential to be affected by	) <b>y</b>	
	.,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FIRH11

Facility ID:

004428 If continuation sheet Page 6 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	00	- COM 03/21	e survey pleted /2011	
NAME OF	PROVIDER OR SUPPLIE OUSE	R	2410 E	ADDRESS, CITY, STATE, ZIP CO EAST MCGALLIARD ROA EIE, IN47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	PECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	TROFFICE	DATE
	the facility and	interview on 3/16/11 at		the same deficient pra	ctice and	
	8:30 a.m. with t	he Administrator, she		what corrective action		
	1	lent #28 received insulin		taken? No other reside		
	1	"Buddy System." She		found to be affected. Di		
	1	• •		residents were re-asses	-	
		cility made arrangements		the Wellness Director u	•	
	for another resid	dent who resided in the		Medication Self Adminis Assessment tool and w		
	facility (Residen	nt #32) to administer		deemed capable of safe		
	Resident #28's i	nsulin.		and self administration	-	
				medication per our police		
	The clinical record for Resident #28 was reviewed on 3/16/11 at 2:30 p.m.			Wellness Director revie	•	
				assessment with the nu		
				practitioner and obtained	ed	
				physician orders as to t	:he	
	Resident #28's o	current diagnoses included,		resident's ability to safe	ely self	
	but were not lin	nited to diabetes mellitus		administer. Residents v	vill be	
	and dementia.			re-assessed no less that		
	and dementia.			quarterly or as needed Wellness Director to en	-	
	Resident #28 ha	nd a physician's order,		continued compliance.	What	
	dated 1/13/11, f	or the following,		measures will be put in	nto place	
	<b>'</b>	2,		or what systemic char	nges will	
	Dlood sugar ma	nitoring twice daily and		the facility make to en	sure that	
	1			the deficient practice of		
	1	ng scale insulin coverage		recur? The Residence		
	1 -	Flexipen according to		Wellness Director, and		
	scale below (fri	end to administer insulin if		were re-trained regarding	•	
	RN not availabl	e)		policy and procedure for		
				completing the Medicat		
	150 - 200 = 2  up	nits		Administration tool, Phy Orders, and resident ch		
	201 - 250 = 4  un			condition. The nurse pr	•	
				established parameters		
	251 - 300 = 6 units			diabetic residents as to		
	301 - 350 = 7  u			blood sugars for physic		
	351 - 400 = 8  un	its		family notification. How		
	more than 400 =	= 10 units		corrective action(s) wi	ill be	
	if greater than 4	50 = call physician		monitored to ensure the	he	
		1 5		deficient practice will		
	During an interv	viony with the	1	i.e., what quality assur	rance	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	BUILDING 00 COMPLETED				
			B. WIN	G		03/21/20	011	
NAME OF	PROVIDER OR SUPPLIE	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
THE OI	I NO VIDER OR SOIT EIEI			2410 EAST MCGALLIARD ROAD				
LYND H	OUSE			MUNCI	E, IN47303			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Administrator or	n 3/21/11 at 9:30 a.m., she			program will be put into plac	e?		
	indicated the Dir	rector of Nursing for the			The Residence Director,			
	facility was norr	nally only in the building			Wellness Director, and/or Designee will perform an ongo	oina		
	Monday thru Fri	day on day shift. She			weekly review of change of	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	1 *	the Director of Nursing			condition, the Medication			
	1	ensed nurse in the facility.			Administration Records, and			
	1	e evening dose of sliding			service notes to ensure contin			
		rerage was routinely given			compliance with the policy and			
	1				procedure regarding residents experiencing a change of			
	to Resident #28 by another resident who				condition, diabetic monitoring,			
lived at the facility, Resident #32.					and documentation. Findings	will		
					be reviewed and corrected			
	This indicated Resident #28 was receiving				through our QA process. The			
	sliding scale inst	•			Regional Director of Quality ar	nd		
	administered by	another resident instead			Care Management and/or	.		
	of licensed staff,	which was not in			Regional Director of Operation will review the process during	15		
	agreement with	facility policy and state			routine site visits at least mont	thly.		
	regulations. The	e clinical record also			By what date will the system	-		
	1 -	tation of the sliding scale			changes be completed?			
	1	having been given as			Compliance Date: 4/30/11			
	ordered on multi				R0036, R0090, R0091 Will the	•		
		F			Residence Director, the Wellness director, and/ or			
	Refer to ROO1 R	R117, R241, and R245 for			designee complete weekly			
	additional inform				reviews on all residents with			
		mation.			condition changes, all			
	2 D :1 4 1/51	1 1 1			medication records, and all			
	1 ′	s clinical record was			service notes? Will the QA			
		6/11 at 3:00 p.m. The			process for reviewing and			
		ses included, but was not			correcting any findings			
	limited to diabet	es mellitus.			continue indefinitely? Pleas	e		
					specify how often this QA monitoring will occur and for	.		
	The clinical reco	ord indicated the facility			how long? What is the criter			
	was to administe	er all medications to the			for discontinuing if less than			
	resident with the	exception of insulin			six months? The Wellness			
	injections which	the resident was able to			Director and/or Designee will			
	self administer.				complete 1 random weekly rev	/iew		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		03/21/2011
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER		2410 E	EAST MCGALLIARD ROAD	
LYND HO	DUSE		l l	CIE, IN47303	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG	The resident's Jan Recapitulation O not dated by the I resident had order every morning at meals. There was Instaglucose past use as directed at blood sugars below an order to self at Lantus Solostar in 8:00 a.m.  Review of the Jan Administration Review of the resident had the resident had the resident had the resident for the clinical record documentation of the readings, the Instaglucos of the low During an interview Nursing on 3/17/indicated the resident had the Instaglucose.	nuary, 2011, Physician orders were signed, but Nurse Practitioner. The ers for blood sugar checks and every evening before as an order for the [for low blood sugar] and to call the M.D. for the ers downward units of the insulin every morning at the following 8:00 a.m.	TAG	of residents experiencing a change of condition for a period of three months by reviewing Medication Administration Reand Service Notes. Findings was be reviewed after three month by the Residence Director and Wellness Director to determine the need for ongoing monitoring by the QA process. Findings suggestive of 100%compliance will result in no further monito from the Wellness Director or Designee unless otherwise deemed necessary. R0090, R0091: How will the facility ensure insulin injections are administered by a licensed nurse on all at all times if the resident cannot self administering their own insulin? The Residence Director, Wellness Director, and staff were re-educated to their scope of practice and state ruling R000 R0091. Residents who have insulin injections will be reviewed with the Medication Self Administration Assessment not less than quarterly on an ongo basis. When findings indicate a resident is no longer able to safely administer insulin injection the findings will be reviewed with the resident, responsible party and physician. An order will be obtained from the physician a arrangements made for scheduling a licensed nurse to administer the insulin injection required	od the cord vill as d/or e ang e ering  o o o o o o o o o o o o o o o o o o
			1	i	

PRINTED: 04/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  On COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	03/21/2011
			B. WING	A DDDEGG CITY GTATE ZID CODE	03/21/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE AST MCGALLIARD ROAD	
LYND HC	OUSE		l l	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1710		readings noted above and	17.10	·	DATE
	_	umentation of the			
	physician having				
	physician naving	, occir notifica.			
	Refer to R036 an	d R214 for additional			
	information.				
	(1) The Control of				
R0091		all establish and implement anual to ensure that resident			
	care and facility of				
	attained, to include	•			
	(1) The range of some (2) Residents' righ				
	(3) Personnel adm				
	(4) Facility operation				
	•	be made available to			
ı	residents upon rec	review and interview, the	R0091	What corrective action(s) wil	04/30/2011
		ensure the nursing staff	10071	be accomplished for those	04/30/2011
	_	policy and procedures in		residents found to have beer	1
	-	ministration of insulin for		affected by this deficient	
	_	eviewed for insulin		<b>practice?</b> No other residents were found to be affected.	
	administration in	sample of 9. [Resident		Resident # 28's medical condi	tion
	# 28]			and blood sugars were review	ed
	<del>-</del>			by the licensed medical professional with new orders	
	Findings include:	<u>.</u>		obtained. The Residence Dire	ctor
				and Wellness Director made	
	1) The clinical re	ecord for Resident #28		arrangements to ensure insuling administration orders were	n
	was reviewed on	3/16/11 at 2:30 p.m.		covered in the event a license	d
				nurse is not available by	
		arrent diagnoses included,		appropriately licensed person	
		ted to diabetes mellitus		Resident #5 was assessed by nurse practitioner and the	uie
	and dementia.			Wellness Director completed t	he
				Medication Self Administration	I
	Resident #28 had	l a physician's order,		Assessment and a new order	was

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY  COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUII	LDING	<del></del>	03/21/2011	
			B. WIN			03/21/2011	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					AST MCGALLIARD ROAD		
LYND HO	DUSE			MUNC	IE, IN47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	dated 1/13/11, fo	or the following,			obtained. How the facility w	I	
					identify other residents hav	-	
	Blood sugar mor	nitoring twice daily and			the potential to be affected	-	
		ng scale insulin coverage			the same deficient practice what corrective action will be	I	
		Flexipen according to			taken? No other residents w		
	1 ~ ~	and to administer insulin if			found to be affected. Diabetic		
	RN not available				residents were re-assessed to		
	KN HOL available	<del>5)</del>			the Wellness Director utilizing	•	
					Medication Self Administration	n	
	150 - 200 = 2 units				Assessment tool and were		
201 - 250 = 4 units					deemed capable of safe store	age	
	251 - 300 = 6 units				and self administration of medication per our policy. The	۵	
	301 - 350 = 7  un	its			Wellness Director reviewed t		
	351 -400 = 8 uni	its			assessment with the nurse		
	more than 400 =	10 units			practitioner and obtained		
	if greater than 45	50 = call physician			physician orders as to the		
		1 3			resident's ability to safely sel	• • • • • • • • • • • • • • • • • • •	
	The January and	February 2011			administer. Residents will be re-assessed no less than		
	*	ninistration Records for			quarterly or as needed by the	,	
		ked indication the			Wellness Director to ensure		
					continued compliance. What		
		eived the sliding scale			measures will be put into pl		
	1	as ordered by the			or what systemic changes v		
	1 1 1	dates and time noted			the facility make to ensure t		
	below,				the deficient practice does		
					recur? The Residence Directive Wellness Director, and QMA		
	January 2011				were re-trained regarding the		
					policy and procedure for Dial		
	January 3, at 7:0	00 p.m., blood sugar was			Monitoring, change of conditi	• • • • • • • • • • • • • • • • • • •	
	168. The resider	nt should have received 2			and documentation. Upon		
	units of insulin c	coverage. No insulin was			notification of changes, the		
	documented as g				Wellness Director will provide		
	accamonica as g	5- · <del></del> -			instruction as to further action deemed necessary. The	1 45	
	Innuary 6 at 0.0	0 a m blood gugar was			Residence Director and/or		
	I -	0 a.m., blood sugar was			Wellness Director will review		
		nt should have received 2			incident reports and service	notes	
	units of insulin c	coverage. No insulin was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to ensure continued compliance. documented as given. How will the corrective action(s) will be monitored to January 13, at 8:00 a.m., blood sugar was ensure the deficient practice 232. The resident should have received 4 will not recur, i.e., what quality units of insulin coverage. No insulin was assurance program will be put into place? The Residence documented as given. Director, Wellness Director, and/or Designee will perform an February 2011 ongoing weekly review of change of condition. Medication Administration Records, and February 10, at 8:00 a.m., blood sugar service notes to ensure continued was 170. The resident should have compliance with our policy and received 2 units of insulin coverage. No procedure regarding residents insulin was documented as given. experiencing a change of condition, diabetic monitoring, and documentation. Findings will February 13, at 8:00 a.m., blood sugar be reviewed and corrected was 229. The resident should have through our QA process. The received 4 units of insulin coverage. No Regional Director of Quality and Care Management and/or the insulin was documented as given. Regional Director of Operations will review this procedure during February 13, at 7:00 p.m., blood sugar routine site visits at least monthly. was 284. The resident should have By what date will the systemic received 6 units of insulin coverage. No changes be completed? Compliance Date: 4/30/11 insulin was documented as given. R0036, R0090, R0091 Will the Residence Director, the February 15, at 8:00 a.m., blood sugar Wellness director, and/ or was 188. The resident should have designee complete weekly received 2 units of insulin coverage. No reviews on all residents with condition changes, all insulin was documented as given. medication records, and all service notes? Will the QA February 24, at 8:00 a.m., blood sugar process for reviewing and was 154. The resident should have correcting any findings received 2 units of insulin coverage. No continue indefinitely? Please specify how often this QA insulin was documented as given. monitoring will occur and for

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			B. WING			03/21/2011
NAME OF E	PROVIDER OR SUPPLIER		2	2410 E	ADDRESS, CITY, STATE, ZIP CODE AST MCGALLIARD ROAD E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	February 26, at 8 was 155. The re received 2 units insulin was document of the received 3/16/2 additional information related to Reside received sliding ordered by the platime noted above. During an interval Nursing on 3/17/2 indicated she had provide to indicate received any insuland time noted at Review of the compolicy, titled "Additional information of the resident of the resident/familion on State Regulat staff ability and the resident (i.e. states some state, only	isolam., blood sugar sident should have of insulin coverage. No mented as given.  iew with the Director of 11 at 4:15 p.m., nation was requested in #28 not having scale insulin coverage as nysician on the dates and expected in			how long? What is the criter for discontinuing if less than six months? The Wellness Director and/or Designee will complete 1 random weekly re of residents experiencing a change of condition for a period of three months by reviewing Medication Administration Reand Service Notes. Findings who have reviewed after three month by the Residence Director and Wellness Director to determine the need for ongoing monitoring by the QA process. Findings suggestive of 100 %compliant will result in no further monitor from the Wellness Director or Designee unless otherwise deemed necessary. R0090, R0091: How will the facility ensure insulin injections are administered by a licensed nurse on all at all times if the resident cannot self administing their own insulin? The Residence Director, Wellness Director, and staff were re-educated to their scope of practice and state ruling R009 R0091. Residents who have insulin injections will be review via the Medication Self Administration Assessment no less than quarterly on an ongoing basis. When findings indicate a resident is no longer able to safely administer insulin injection the findings will be reviewed withe resident, responsible party	ria n view od the cord will as d/or e ng ce ring  ce ring  o o o o o o o o o o o o o o o o o o
		nnage their injections"			and physician. An order will b	e

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/21/2011
NAME OF F	PROVIDER OR SUPPLIER		2410 E	ADDRESS, CITY, STATE, ZIP CODE AST MCGALLIARD ROAD IE, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0117	qualifications, and applicable state lat twenty-four (24) hunscheduled need services provided qualifications, and depend on skills respecific needs of one (1) awake state and first aid certifit times. If fifty (50) of facility regularly reservices or admin both, at least one shall be on site at facilities with over residents regularly nursing services or medication, or both (1) additional nursion duty at all time (50) residents. Pe	sufficient in number, I training in accordance with laws and rules to meet the our scheduled and ds of the residents and The number, I training of staff shall equired to provide for the the residents. A minimum of off person, with current CPR cates, shall be on site at all for more residents of the eccive residential nursing istration of medication, or (1) nursing staff person all times. Residential one hundred (100) or receiving residential or administration of th, shall have at least one sing staff person awake and s for every additional fifty rsonnel shall be assigned for which they are trained to		obtained from the physician a arrangements made for scheduling a licensed nurse to administer the insulin injection required.	)
	perform. Employe written job descrip	e duties shall conform with otions.	R0117	What corrective action(s) wi	I 04/30/2011
	facility failed to sufficient license monitor diabetic sliding scale insu- residents reviewe sliding scale insu-	review and interview, the ensure there was ed staff available to residents and administer alin as ordered for 1 of 5 ed for administration of alin in a sample of 9.  Resident # 32 was	KU11/	be accomplished for those residents found to have been affected by this deficient practice? The Residence Director and/or Wellness Director and/or Wellness Director and/or wellness data available to administer insulin Resident #28. How the facility will identify other residents having the potential to be	n ctor f is to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administering insulin to Resident # 28 as affected by the same deficient practice and what corrective licensed staff were not available. action will be taken? No other residents were found to be Findings include: affected. What measures will be put into place or what systemic changes will the facility make During the initial walk- through tour of to ensure that the deficient the facility and interview on 3/16/11 at practice does not recur? The 8:30 a.m., with the Administrator, she Residence Director and Wellness indicated Resident #28 received insulin Director were re-educated to coverage on the "Buddy System." She Indiana state ruling R117 410 IAC 16.2-5-1.4 (b) Personnel. The indicated the facility made arrangements Residence Director and/or for another resident who resided in the Wellness Director will ensure facility (Resident #32) to administer provisions are made to ensure a Resident #28's insulin. licensed staff is available and sufficient in number and qualifications to monitor and The clinical record for Resident #28 was administer sliding scale insulin as reviewed on 3/16/11 at 2:30 p.m. order by their physician. How will the corrective action(s) will be Resident #28's current diagnoses included, monitored to ensure the deficient practice will not recur, but were not limited to diabetes mellitus i.e., what quality assurance and dementia program will be put into place? The Residence Director, A nursing note entry, dated 1/10/11 at Wellness Director, and/or Designee will perform an ongoing 1:30 p.m., signed by the Director of weekly review of the Medication Nursing, indicated the following, Administration Record and staffing schedule to ensure " Pt's [patients] son here @ [at] this time continued compliance with Indiana state ruling R117 410 IAC and went over [with] him that pt is having 16.2-5-1.4 (b) Personnel. more trouble doing his insulin pen, Findings will be reviewed and explained to son that the nurse corrected through our QA practitioner is gonna try and stabilize him process. The Regional Director of Quality and Care Management more on p.o. [oral] meds [medications and and/or Regional Director of just try coverage ss [sliding scale]. Pt Operations will review the does have a friend here [Resident #32]

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 03/21/2011				
			B. WIN			03/21/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
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1710	who is capable of giving pt coverage in			mo	schedule and ensure compliar		
	_	should need it. The			during routine site visits at least		
		er own meds and is a & o			monthly. By what date will the		
					systemic changes be		
	l <sup>-</sup>	ed] x [times] 3 and			completed? Compliance Date	:	
		tates, "I understand." Will			4/30/11 R0117: Will the QA process for		
		tor bs [blood sugar]			reviewing and correcting any		
	while switching t	to pill form."			findings continue indefinitely?		
	D 11 . //201				Please specify how often this QA		
	Resident #28 had a physician's order, dated 1/13/11, for the following,  Blood sugar monitoring twice daily and				monitoring will occur and for he		
					long. If less than six months, wl		
					monitoring?	the	
					A random audit will be completed	d	
	l '	g scale insulin coverage			weekly by the Residence Director		
	-	Flexipen according to			and/or the Wellness Director for a	l l	
	· ` `	nd to administer insulin if			period of three months. Findings		
	RN not available	)			be reviewed after three months by the Residence Director and/or	y	
					Wellness Director to determine the	ne	
	150 - 200 = 2  uni				need for ongoing monitoring by t	he	
	201 - 250 = 4  uni				QA process. Findings suggestive		
	251 - 300 = 6  uni				compliance will result in no furth	er	
	301 - 350 = 7  uni				monitoring from the Wellness Director or Designee unless		
	351 - 400 = 8  unit				otherwise deemed necessary.		
	more than 400 =						
	if greater than 45	0 = call physician					
		nuary, February and					
		ication administration					
	records for Resid	lent #28 indicated the					
	resident received	sliding scale insulin					
	coverage 46 time	es in January, 38 times in					
	February, and 17	times in March.					
	Resident #28's bl	ood sugar results which					
	required sliding s	scale insulin coverage					
	ranged from 152	to 391.					

Facility ID:

PRINTED: 04/29/2011 FORM APPROVED OMB NO. 0938-0391

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			B. WINC			03/21/2	011
NAME OF I	PROVIDER OR SUPPLIEI	ξ.	STREET ADDRESS, CITY, STATE, ZIP CODE 2410 EAST MCGALLIARD ROAD MUNCIE, IN47303				
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TAG	During an intervent Administrator or indicated the Diracility was normal Monday thru Fristurther indicated was the only lice. She indicated the scale insulin coverage to Resident #28 lived at the facil. Review of the Jamarch 2011 means records for Resident received coverage 23 times the month of Jamarch of March. Review of the composition of March. Review of the composition of March. Scale Insulin Conditional Conditions and indicated the following scale insuling the resident/famon State Regular staff ability and resident (i.e. stall resident (i.e. s	an 3/21/11 at 9:30 a.m., she rector of Nursing for the mally only in the building day on day shift. She is the Director of Nursing ensed nurse in the facility. The evening dose of sliding verage was routinely given by another resident who sity, Resident #32.  Innuary, February and dication administration dent #28 indicated the disliding scale insuling es in the evening hours in mary, 18 times in the ary, and 6 times in the ary, and ary are		TAG	DEFICIENCY)		DATE

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administer insulin to residents who are unable to self-manage their injections...." R0154 (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. R0154 What corrective action(s) will 04/30/2011 Based on observation, record be accomplished for those review, and interview, the facility residents found to have been failed to ensure proper storage of affected by this deficient practice? No residents were non-dairy creamer and straws, and found to be affected. How the failed to ensure the exterior portion facility will identify other of the lids to dry storage bins, and residents having the potential to be affected by the same serving carts were in a clean and deficient practice and what sanitary condition for 1 of 3 corrective action will be taken? No other residents were found to observations of kitchen sanitation. be affected. What measures will This deficient practice had the be put into place or what potential to affect 44 residents that systemic changes will the facility make to ensure that the received meals from the kitchen in deficient practice does not the population of 45. recur? The Dining Service Coordinator cleaning schedule was updated to include the Findings include: following items; storage bins, and serving carts. The Dining Service Coordinator was re-trained During a tour of the facility's regarding the revised cleaning kitchen conducted with the Dining schedule to be completed monthly along with proper storage Services Coordinator on 3/16/11 at of non dairy creamer and straws. 8:30 a.m., the following The Residence Director will complete random rounds of observations were made: kitchen area to ensure continued compliance with our safety and sanitation standards. How will a.) The lids to the dry storage bins the corrective action(s) will be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED
			B. WIN	IG		03/21/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2410 EAST MCGALLIARD ROAD  MUNCIE, IN47303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	rice, powdered powdered mill drips and spill substances.  b.) The tops of carts were crace. This resulted if being thorough sanitized. The with dried drip c.) The white soiled with dried debris.  d.) Non-dairy were stored until the drain, in the During an interpolation of the lids to the to be cleaned of weekend person.	of the two tan serving cked, and melted. In the surfaces not half cleaned and carts were soiled to and/or food debris.  Serving cart was the drips and/or food  Creamer and straws the drips and/or food			monitored to ensure the deficient practice will not re i.e., what quality assurance program will be put into pla The Dining Service Coordina was re-trained regarding the revised kitchen cleaning sche and the food safety and sanit standards. The Residence Director and/or Designee will complete random walking rou of the kitchen to ensure conticompliance. Findings will be reviewed and corrected throuthe QA process. The Region Director of Quality and Care Management and/or Regiona Director of Operations will conduct a kitchen inspection during site visits at least mon By what date will the system changes be completed? Compliance Date: 4/30/11 R0154: How often will the Residence Director complete random rounds of the kitchen and for how long? If less than months, what is the criteria for discontinuing the monitoring? Will the QA process for review and correcting any findings continue indefinitely? Please specify how often this QA monitoring will occur and for long. If less than six months, vis the criteria for discontinuing monitoring?  The Residence Director and/or Designee will complete random rounds three days a week for a pof three months concerning the	ce? tor  edule ation  unds nued  gh al  thly. nic  area six  ing  now what g the daily
					ļ	

<b>l</b> i '		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  00			COMPLETED	
			B. WING		03/21/2011
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
LYND HC	OUSE		I	EAST MCGALLIARD ROAD ICIE, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		10.2,	(X5)
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TAG	*	LSC IDENTIFYING INFORMATION)	TAG	DATE	
	Administrator	on 3/17/11 at 1:35		kitchen safety and sanitation standards to ensure continued	
	p.m., she indic	ated the kitchen was		compliance through corrective ac	tion
	cleaned on 3/1	5/11, and they did		and accountability with appropria	
	not think to cle	ean the lids on the dry		staff assigned specific duties. Findings will be reviewed after the	uraa
	storage bins.			months by the Residence Directo	
	C			and/or Wellness Director to	
	Review of the	updated 5/2007,		determine the need for ongoing monitoring by the QA process.	
	Kitchen cleani	_		Findings suggestive of compliance	ce
		e Administrator, on		will result in no further monitoring	ng
	3/17/11 at 2:10	· · · · · · · · · · · · · · · · · · ·		from the Wellness Director or Designee unless otherwise deeme	ad l
		ng of the lids of the		necessary.	
	dry storage bin	•			
	dry storage on	15.			
R0214	each resident shal admission and sha semiannually and change in the reside often at the reside licensed nurse sha needs of the reside		P0214	What corrective action(s) will	I 04/20/2011
	facility failed to ediabetes mellitus.	review and interview, the ensure a resident with who self- administered uated and monitored	R0214	What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #5 was	* ***********************************
	when morning bl	ood sugar levels were		re-assessed by the nurse	
	low and morning			practitioner and the Wellness Director utilizing the Medicatio	n
	administered for			Self Administration Assessmen	
	` '	viewed for monitoring of		and a new order was obtained	
	low blood sugars	in a sample of 9.		How the facility will identify	
	Findings include:	:		other residents having the potential to be affected by th same deficient practice and	e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 1. Resident #5's clinical record was what corrective action will be taken? No other residents were reviewed on 3/16/11 at 3:00 p.m. The found to be affected. Diabetic resident's diagnoses included, but was not residents were re-assessed by limited to diabetes mellitus. the Wellness Director utilizing the Medication Self Administration Assessment tool and were The clinical record indicated the facility deemed capable of safe storage was to administer all medications to the and self administration of resident with the exception of insulin medication per our policy. The injections, which the resident was able to Wellness Director reviewed the assessment with the nurse self administer. practitioner and obtained physician orders as to the The resident's January, 2011, Physician resident's ability to safely self Recapitulation Orders were signed, but administer. Residents will be re-assessed no less than not dated by the Nurse Practitioner. The quarterly or as needed by the resident had orders for blood sugar checks Wellness Director to ensure every morning and every evening before continued compliance. What meals. There was an order for measures will be put into place Instaglucose paste [for low blood sugar] or what systemic changes will the facility make to ensure that use as directed and to call the M.D. for the deficient practice does not blood sugars below 60. The resident had recur? The Residence Director, an order to self administer 34 units of Wellness Director, and QMA's Lantus Solostar insulin every morning at were re-trained regarding the policy and procedure for 8:00 a.m. completing the Medication Self Administration tool, Resident Review of the January, 2011, Medication Assessment, and reporting Administration Record [MAR] indicated change of condition. The nurse the resident had the following 8:00 a.m. practitioner established parameters for diabetic residents blood sugars: as to abnormal blood sugars that are to be communicated with the 1/21/11 - 55 physician, along with management of low blood sugar. 1/22/11 - 59 How will the corrective action(s) will be monitored to The clinical record lacked any ensure the deficient practice information related to the physician

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FIRH11

Facility ID:

004428

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE having been contacted, the Instaglucose will not recur, i.e., what quality assurance program will be put paste having been applied as ordered, or into place? The Residence any followup assessments having been Director, Wellness Director, completed related to the low blood sugar and/or Designee will perform an readings. The clinical record indicated ongoing weekly review of service notes, change of condition reports the resident had continued to self and nursing assessments to administer his morning insulin on the ensure continued compliance with dates when his blood sugars were below the policy and procedure 60 without documentation of any follow regarding the resident assessment process. Findings up assessments having been completed. will be reviewed and corrected through the QA process. The During an interview with the Director of Regional Director of Quality and Nursing on 3/17/11 at 10:10 a.m., she Care Management and/or Regional Director of Operations indicated the facility performs the blood will review the process during sugar checks for Resident #5 and observes routine site visits at least monthly. the insulin administration by the resident. By what date will the systemic She indicated the resident did self changes be completed? administer his insulin on 1/21/11 and Compliance Date: 4/30/11 R0214: Will the Residence 1/22/11. She indicated the resident had **Director, the Wellness Director,** not received the Instaglucose. She and/or designee complete indicated no assessments had been done weekly reviews of service following the low blood sugar readings notes on all residents with and the subsequent administration of condition changes? Will the QA process for reviewing and insulin. correcting any findings continue indefinitely? Please specify how often this QA monitoring will occur and for how long. If less than six month, what is the criteria for discontinuing the monitoring? The Wellness Director and/or Designee will complete 1 random weekly review of residents experiencing a change of condition for a period of three

	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED  03/21/2011
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R0241	(e) The administration provision of reside as ordered by the shall be supervise the premises or or (1) Medication shallicensed nursing predication aides. Based on record facility failed to a insulin coverage the physician and licensed staff for for sliding scale in the provision of the provision and the physician and	tion of medications and the ntial nursing care shall be resident 's physician and d by a licensed nurse on a call as follows: all be administered by ersonnel or qualified review and interview, the ensure sliding scale was given as ordered by a daministered only by 1 of 1 resident reviewed nsulin administration administer medications a sample of 9.	R0241	months by reviewing the Medication Administration Rec and Service Notes concerning continued compliance through corrective action and accountability with appropriate staff. Findings will be reviewed after three months by the Residence Director and/or Wellness Director to determine the need for ongoing monitoring by the QA process. Findings suggestive of 100% compliant will result in no further monitor from the Wellness Director or Designee unless otherwise deemed necessary.  What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident # 28's medical condition and blood sugars were reviewed by the licensed medical professional with new orders obtained. The Residence Director and Wellin Director made arrangements are nesure insulin administration orders were covered in the evalue licensed nurse is not availably appropriately licensed personnel. How the facility widentify other residents havi	cord In each de eng loce ening Il 04/30/2011 In each essession ent ole

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
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				the potential to be affected I	ру
				the same deficient practice	and
				what corrective action will b	e
				taken? No other residents we	ere
				found to be affected. Diabetic	:
				residents were re-assessed b	y
				the Wellness Director utilizing	the
				Medication Self Administration	n
				Assessment tool and were	
				deemed capable of safe stora	ige
				and self administration of	
				medication per the policy. The	
				Wellness Director reviewed th	ne
				assessment with the nurse	
				practitioner and obtained	
				physician orders as to the	
				resident's ability to safely self	
				administer. Residents will be	
				re-assessed quarterly or as	
				needed by the Wellness Direct	ctor
				utilizing the Medication Self	
				Administration Assessment to	
				ensure continued compliance	
				What measures will be put i	nto
				place or what systemic	
				changes will the facility mak	(e
				to ensure that the deficient	
				practice does not recur? The	
				Residence Director, Wellness	
				Director, and staff were re-tra	
				regarding the Indiana State r	
				R241 410 IAC 16.2-5-4 (e) (1	' I
				Health Services. The Resider Director and Wellness Director	
				will ensure provisions are ma	
				for residents to receive inject	
				medications in accordance w	
				Indiana state ruling R 241 41	
				IAC 16.2-5-4 (e) (1) Health	<b>´</b>
				Services. Residents will be	
				re-assessed quarterly or as	
				. o docoood quarterly of as	

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	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 03/21/2011
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				needed by the Wellness Direct utilizing the Medication Self Administration Assessment to ensure continued compliance safe administration and storage of the prescribed medication regimen. How will the corrective action(s) will be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place The Residence Director, Wellness Director, and/or Designee will ensure provision are made to ensure a licensed staff member is available and sufficient in number and qualifications to monitor and administer sliding scale insuling ordered by their physician. The Wellness Director will perform weekly reviews of the Medica Administration Record and staschedule to ensure continued compliance. The Regional Director of Quality and Care Management and/or Regional Director of Operations will revisit staffing needs and compliance during routine site visits at least monthly. By what date will the systemic changes be completed? Compliance Date 4/30/11  R0241: How will the facility ensure insulin injections are administered by a licensed nurson all shifts at all times if the resident cannot self administer their own insulin? Will monthly will monthly will monthly.	with ge  cur,  ce?  ns  d  n as as  ie  ition  aff  liew  e  ist  ie  e:  ce:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/21/2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2410 EAST MCGALLIARD ROAD  MUNCIE, IN47303				
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	was reviewed on Resident #28's cours but were not limited and dementia.  During the initiathe facility and in 8:30 a.m., with the indicated Reside coverage on the indicated the factor another residence.	record for Resident #28 3/16/11 at 2:30 p.m.  arrent diagnoses included, ited to diabetes mellitus  I walk- through tour of interview on 3/16/11 at ine Administrator, she ent #28 received insulin 'Buddy System." She illity made arrangements ent who resided in the t #32) to administer		reviews of staffing needs continindefinitely? What is the criter for discontinuing these reviews less than six months?  The Residence Director, Wellne Director, and staff were re-educto their scope of practice and staruling R0090, R0091. Residents have insulin injections will be reviewed via the Medication Sel Administration Assessment no I than quarterly on an ongoing ba When findings indicate that a resident is no longer able to safe administer insulin injections the findings will be reviewed with tresident, responsible party, and physician. An order will be obtained from the physician and arranger made for scheduling a licensed to administer the insulin injection required.  What corrective action(s) where accomplished for those residents found to have been affected by this deficient practice? Resident # 28's medical condition and blood sugars were reviewed by the licensed medical professional with new orders obtained. The Residence Director and Wellin Director made arrangements ensure insulin administration orders were covered in the evaluation of the proposition of the propos	ria sif ss sated te who  off ess sis. ely he ined nents nurse on as  ill 04/30/2011  en  l e ness to went ble vill ing by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident #28's insulin. what corrective action will be taken? No other residents were found to be affected. Diabetic Resident #28 had a physician's order, residents were re-assessed by dated 1/13/11, for the following, the Wellness Director utilizing the Medication Self Administration Assessment tool and were Blood sugar monitoring twice daily and deemed capable of safe storage administer sliding scale insulin coverage and self administration of using Humalog Flexipen according to medication per the policy. The scale below (friend to administer insulin if Wellness Director reviewed the assessment with the nurse RN not available) practitioner and obtained physician orders as to the 150 - 200 = 2 units resident's ability to safely self 201 - 250 = 4 units administer. Residents will be re-assessed quarterly or as 251 - 300 = 6 units needed by the Wellness Director 301 - 350 = 7 units utilizing the Medication Self 351 - 400 = 8 units Administration Assessment to more than 400 = 10 units ensure continued compliance. What measures will be put into if greater than 450 = call physicianplace or what systemic changes will the facility make The January and February 2011 to ensure that the deficient Medication Administration Records for practice does not recur? The Resident #28 lacked indication the Residence Director, Wellness Director, and staff were re-trained resident had received the sliding scale regarding the Indiana State ruling insulin coverage as ordered by the R241 410 IAC 16.2-5-4 (e) (1) physician on the dates and time noted Health Services. The Residence below, Director and Wellness Director will ensure provisions are made for residents to receive inject able January 2011 medications in accordance with Indiana state ruling R 241 410 January 3, at 7:00 p.m., blood sugar was IAC 16.2-5-4 (e) (1) Health Services. Residents will be 168. The resident should have received 2 re-assessed quarterly or as units of insulin coverage. No insulin was needed by the Wellness Director documented as given. utilizing the Medication Self Administration Assessment to

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	E CONSTRUCTION  00	(X3) DATE COMP 03/21/2	LETED
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IAU	January 6, at 8:0 184. The resider units of insulin conduction documented as graduary 13, at 8: 232. The resider units of insulin conduction documented as graduary 2011  February 2011  February 10, at 8 was 170. The reserved 2 units insulin was documented as graduary 13, at 8 was 229. The reserved 4 units insulin was documented 6 units insulin was documented 7 units insulin was documented 8 units ins	0 a.m., blood sugar was at should have received 2 overage. No insulin was given.  00 a.m., blood sugar was at should have received 4 overage. No insulin was	IAU	ensure continued complia safe administration and sto of the prescribed medicat regimen. How will the corrective action(s) will monitored to ensure the deficient practice will not i.e., what quality assurar program will be put into. The Residence Director, Wellness Director, and/or Designee will ensure provare made to ensure a lice staff member is available sufficient in number and qualifications to monitor a administer sliding scale in ordered by their physiciar Wellness Director will per weekly reviews of the Me Administration Record an schedule to ensure contincompliance. The Regiona Director of Quality and Ca Management and/or Regional Director of Operations will staffing needs and compliaduring routine site visits a monthly. By what date with systemic changes be completed? Compliance 4/30/11  R0241: How will the facility ensure insulin injections are administered by a licensed on all shifts at all times if the resident cannot self adminition their own insulin? Will more reviews of staffing needs condefinitely? What is the condefinitely?	ince with corage ion  be  t recur, nce place?  risions nsed and  nd sulin as a. The form dication d staff nued al are onal I review ance t least ill the  Date:  ty e nurse ne ster onthly ontinue riteria	DATE

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	received 2 units	of insulin coverage. No			less than six months?	
	insulin was docu	mented as given.			The Residence Director, Wellness	
		8			Director, and staff were re-educat	
	Echmony 26 at 9	:00 a.m., blood sugar			to their scope of practice and state	
	•				ruling R0090, R0091. Residents v	vho
		sident should have			have insulin injections will be	.
		of insulin coverage. No			reviewed via the Medication Self	
	insulin was docu	mented as given.			Administration Assessment no les	
					than quarterly on an ongoing basi When findings indicate that a	S.
	During an intervi	iew with the Director of			resident is no longer able to safely	N/
	Nursing on 3/16/11 at 4:15 p.m.,				administer insulin injections the	<sup>y</sup>
		nation was requested			findings will be reviewed with the	e
					resident, responsible party, and	<b>`</b>
		nt #28 not having			physician. An order will be obtain	ned
		scale insulin coverage as			from the physician and arrangement	
	ordered by the pl	nysician on the dates and			made for scheduling a licensed nu	
	times noted abov	re.			to administer the insulin injection	as
					required.	
	During an intervi	iew with the Director of				
	"	11 at 8:30 a.m., she				
	•	I no information to				
	1 ^	te Resident #28 received				
	l •	rage on the dates and time				
	noted above.					
	2.) Review of the	e current undated facility				
	l ′	ubcutaneous Insulin				
	*	ided by the Administrator				
	" ' *	•				
	on 3/18/11 at 2:30 p.m., indicated the					
	following,					
	1. Diabetes Mell	itus (D.M.) is a disorder				
	of carbohydrate	metabolism in which the				
	ability to break d					
	· -	lost due to problems with				
	· -	-				
	insulin productio	ш				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED				
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TAG	` `	LSC IDENTIFYING INFORMATION)				DATE	
R0245	dosing parameter usually consisting number of units to the results of the pre-determined very physician"  (5) Injectable med by licensed person Based on record facility failed to eadministered insurby the physician reviewed with or sample of 9. (Resulting the facility and in 8:30 a.m., with the indicated Reside coverage on the indicated the facility (Resident Resident #28's in the sample of #28's in the sa	review and interview, the ensure a licensed nurse alin injections as ordered for 1 of 5 residents ders for insulin in a sident #28)  walk- through tour of a her Administrator, she ent #28 received insulin Buddy System." She lity made arrangements ent who resided in the st #32) to administer sulin.	R0	245	What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident # 28's medical condition and blood sugars were reviewed by the licensed medical professional with new orders obtained. The Residence Director and Wellned Director made arrangements to ensure insulin administration orders were covered in the everal licensed nurse is not available by appropriately licensed personnel. How the facility will identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken? No other residents were found to be affected. Diabetic residents were re-assessed by the Wellness Director utilizing Medication Self Administration Assessment tool and were	ess o ent le II ng y nd e	04/30/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE deemed capable of safe storage and self administration of Resident #28's current diagnoses included. medication per our policy. The but were not limited to diabetes mellitus Wellness Director reviewed the and dementia assessment with the nurse practitioner and obtained physician orders as to the A nursing note entry, dated 1/10/11 at resident's ability to safely self 1:30 p.m., signed by the Director of administer. Residents will be Nursing, indicated the following, re-assessed quarterly or as needed by the Wellness Director utilizing the Medication Self " Pt's [patients] son here @ [at] this time Administration Assessment to and went over [with] him that pt is having ensure continued compliance. more trouble doing his insulin pen, What measures will be put into explained to son that the nurse place or what systemic changes will the facility make practitioner is gonna try and stabilize him to ensure that the deficient more on p.o. [oral] meds [medications and practice does not recur? The just try coverage ss [sliding scale]. Pt Residence Director. Wellness does have a friend here [Resident #32] Director, and staff were who is capable of giving pt coverage in re-educated to Indiana State ruling R241 410 IAC 16.2-5-4 (e) the evening if he should need it. The (1) Health Services. The friend does do her own meds and is a & o Residence Director and Wellness [alert and oriented] x [times ] 3 and Director will ensure provisions are mobile. Pt son states, "I understand." Will made for residents to receive inject able medications in continue to monitor bs [blood sugar] accordance with Indiana state while switching to pill form." ruling R 241 410 IAC 16.2-5-4 (e) (1) Health Services. Residents will be re-assessed quarterly or Resident #28 had a physician's order. as needed by the Wellness dated 1/13/11, for the following, Director utilizing the Medication Self Administration Assessment Blood sugar monitoring twice daily and to ensure continued compliance administer sliding scale insulin coverage with safe administration and storage of the prescribed using Humalog Flexipen according to medication regimen. How will scale below (friend to administer insulin if the corrective action(s) will be RN not available) monitored to ensure the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED				
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LYND HC					E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION DATE
IAU			+	IAU	Director, and staff were re-educat	ed	DATE
	•	es in the evening hours in uary, 18 times in the			to their scope of practice and state		
		• •			ruling R0090, R0091. Residents v		
		ry, and 6 times in the			have insulin injections will be		
	month of March.				reviewed via the Medication Self		
	D : 0.1	1 4 10 17			Administration Assessment no les		
		rrent, undated facility			than quarterly on an ongoing basi When findings indicate that a	s.	
		lministration of Sliding			resident is no longer able to safely	, I	
	Scale Insulin Coverage", provided by the administrator on 3/17/11 at 2:30 p.m., indicated the following,				administer insulin injections the		
					findings will be reviewed with the	e	
					resident, responsible party, and physician. An order will be obtain		
	G1: 1: 1 ·				from the physician and arrangement		
	_	alin may be managed by			made for scheduling a licensed nu		
		ly or residence depending			to administer the insulin injection		
	_	ions, Nurse Practice Acts,			required.		
		he condition of the					
	`	le and predicable.) In					
		licensed nurses may					
		n to residents who are					
	unable to self-ma	anage their injections"					
D0206	(a) Madiaations of	desiriatored by the facility	ŀ				
R0306		dministered by the facility in compliance with					
		al, state, and local laws, and					
	•	released, returned, or					
		tion shall be documented in					
	the resident 's clir include the followi	nical record and shall					
	(1) The name of the						
	· ·	strength of the drug.					
	(3) The prescription						
	(4) The reason for						
	(5) The amount di (6) The method of	•					
	(7) The date of the	•					
	(8) The signature	of the person conducting					
	the disposal of the						
	(9) The signature	of a witness, if any, to the					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE disposal of the drug. What corrective action(s) will Based on record review and interview, the R0306 04/30/2011 be accomplished for those facility failed to ensure discontinued residents found to have been medications were disposed of in affected by this deficient accordance with facility policy and state practice? No residents were regulations for 1 of 2 closed clinical found to be directly affected. How records reviewed for disposition of the facility will identify other residents having the potential medications in a sample of 9. (Resident to be affected by the same #101) deficient practice and what corrective action will be taken? Findings include: No other residents were found to be affected. What measures will be put into place or what 1.) The clinical record for Resident #101 systemic changes will the was reviewed on 3/16/11 at 3:30 p.m. facility make to ensure that the Diagnoses for Resident #101 included, deficient practice does not but were not limited to, Cerebral Vascular recur? The Wellness Director and licensed staff were re-trained Accident and depression. The facility regarding the policy and staff had identified this record as a "closed procedure for drug disposition record" for a resident transferred to the with appropriate documentation. hospital. The Wellness Director and/or Designee will document the disposition of the medications and During an interview on 3/21/11 at 8:43 place a copy within the resident's a.m., the Administrator indicated Resident clinical record. The Wellness #101 had been transferred to the hospital Director will review resident on 11/19/10 and did not return to the discharges to ensure appropriate documentation regarding drug facility following her hospitalization. disposition is within the resident's clinical record. How will the The November 2010 signed recapitulation corrective action(s) will be of physician's orders indicated Resident monitored to ensure the #101 had medication orders which deficient practice will not recur, i.e., what quality assurance included, but were not limited to: program will be put into place? The Wellness Director and/or Acetaminophen (a pain medication) 325 Designee will conduct monthly milligrams 2 tablets every four hours as reviews of resident who are to be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE discharged to ensure a drug needed for pain or elevated temperature disposition is completed and placed within the resident's Milk of Magnesia (a laxative) 30 record with appropriate milliliters once daily as needed for documentation as indicated within Indiana State ruling R 306 410 constipation IAC 16.2-5-6 (g) (1-9) Pharmaceutical Services. Hydrocodone-Apap (a narcotic pain Findings will be reviewed and medication) one tablet every 6 hours as corrected through the QA process needed for moderate pain until compliance is achieved. The Regional Director of Quality and Care Management will review Vitamin D 50,000 units Softgel one closed charts to ensure that drug capsule every week disposition is appropriately documented during routine site visits at least monthly. By what The clinical record lacked any date will the systemic changes information related to the disposition of be completed? Compliance these medications following the resident's Date: 4/30/11 transfer to the hospital on 11/19/10 and R 0306: Will monthly review of discharged resident records decision not to return following continue indefinitely? What is the hospitalization. criteria for discontinuing these reviews if less than six months? During an interview with the The Wellness Director and or Administrator on 3/21/11 at 10:30 a.m., Residence Director will perform a random review of resident records she indicated the Medication monthly for a period of three months Administration Records for Resident #101 to ensure continued compliance with indicated the Vitamin D had been our policy concerning Clinical discontinued in May 2010 and the Records. Findings will be reviewed Hydrocodone had been discontinued due after three months by the Residence Director and/or Wellness Director to to non-use in July of 2010. She indicated determine the need for ongoing these orders should not have been shown monitoring through our QA process. as current on the November recap of Findings suggestive of compliance physician's orders. The Administrator will result in no further monitoring indicated she was unable to provide any from the Wellness Director or Designee unless otherwise deemed drug disposition information related to necessary. these medications or the other

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AND PLAN OF CORRECTION IDENTIFI		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLI	ETED
			B. WING 03/21/2011			)11	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2410 E	AST MCGALLIARD ROAD		
LYND HOUSE				MUNCI	E, IN47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCE		DATE
	medications note						
	Review of a cu	arrent facility policy,			What corrective action(s) will		04/30/2011
	dated 6/2008,	provided by the			be accomplished for those residents found to have beer	,	
	Administrator	on 3/17/11 at 2:43			affected by this deficient	'	
	·	DRUG DISPOSAL,			practice? No residents were		
	•				found to be directly affected. <b>F</b>	low	
		as not limited to the			the facility will identify other		
	following:				residents having the potentia	al	
					to be affected by the same		
	" 1 If medic	ations are to be			deficient practice and what corrective action will be take	,,	
					No other residents were found		
	• `	g. due to a change in			be affected. What measures v		
	order, disconti	nue order or the			be put into place or what		
	death of a resid	dent), the			systemic changes will the		
	medications sl	nould be returned to			facility make to ensure that t	he	
					deficient practice does not		
		(sic) pharmacy			recur? The Wellness Director and licensed staff were re-train	, d	
	(unless state re	egulations require			regarding the policy and	ieu	
	onsite disposal	l). To return			procedure for drug disposition		
	medications to	the pharmacy:			with appropriate documentatio		
		1 5			The Wellness Director and/or		
	Complete 1	the applicable			Designee will document the		
	•	a Drug Disposal /			disposition of the medications place a copy within the resider		
					clinical record. The Wellness		
		n (prescription			Director will review resident		
	number; name	, strength, and			discharges to ensure appropri		
	quantity of the	medication; and the			documentation regarding drug		
	date in the column "Date				disposition is within the resider	iii S	
	Returned"). Sign the form				corrective action(s) will be		
					monitored to ensure the		
					deficient practice will not rec	ur,	
	Disposal of	Controlled			i.e., what quality assurance		
	Substances				program will be put into plac	e?	
	/				The Wellness Director and/or		
					Designee will conduct monthly		
					reviews of resident who are to	be	

A. BUILDING  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS		/2011			
NAME OF PROVIDER OR SUDDITIES  STREET ADDRESS					
2410 EAST MC	STREET ADDRESS, CITY, STATE, ZIP CODE 2410 EAST MCGALLIARD ROAD MUNCIE, IN47303				
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EAC	PROVIDER'S PLAN OF CORRECTION 'H CORRECTIVE ACTION SHOULD BE 5-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
subject to special disposal requirements in accordance with federal and state laws and regulations. Controlled substances may not be returned to the pharmacy for credit 3. Document on the Narcotic Inventory Sheet how the medications were disposed of at the residence, those individuals involved in the disposal (i.e. the pharmacist or the Residence Director and Nurse) must sign the form 5. Record the disposal of the controlled medications on a Drug Disposal / Release form 6. Narcotic Inventory Sheets are archived with resident records."  disposal record with records disposal disposal involved in the disposal of the controlled medications on a Drug Disposal / Release form  disposal requirements in accordance with record documentation indian records.	arged to ensure a drug sition is completed and d within the resident's d with appropriate mentation as indicated within as State ruling R 306 410 6.2-5-6 (g) (1-9) maceutical Services. It is important to the distribution of the QA process ompliance is achieved. The mal Director of Quality and Management will review d charts to ensure that drug sition is appropriately mented during routine site at least monthly. By what will the systemic changes indefinitely? What is the a for discontinuing these is if less than six months? It is the a for discontinuing these is if less than six months? It is if less than six months in review of resident records ly for a period of three months are continued compliance with licy concerning Clinical dis. Findings will be reviewed are months by the Residence for and/or Wellness Director to the meed for ongoing oring through our QA process. It is greatly suggestive of compliance sult in no further monitoring the Wellness Director or nee unless otherwise deemed arry.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (a) The facility must maintain clinical records R0349 on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. R0349 What corrective action(s) will 04/30/2011 Based on observation, record review, and be accomplished for those interview, the facility failed to ensure residents found to have been resident clinical records were complete affected by this deficient and accurately documented in regards to practice? Resident #32's recapitulations of physician's orders and primary care physician was nursing note information for 2 of 9 contacted by the Wellness Director and the order was residents reviewed for complete and clarified for TED hose to be accurate clinical records in a sample of 9. applied as needed. An order was (Resident #32 and #101) also received for application of the ace wrap to the right arm as needed. The Wellness Director Findings include: re-assessed Resident #32 utilizing the Medication Self 1.) The clinical record for Resident #32 Administration Assessment and deemed the resident capable of was reviewed on 3/16/11 at 9:30 a.m. safe storage and administration Diagnoses for Resident #32 included, but of medications and treatments as were not limited to, hypertension and ordered by the primary care anemia. physician. Appropriate documentation was completed on the Medication Administration A physician's order, dated 11/5/10, Record and the recaps. Orders indicated Resident #32 was to wear knee were signed appropriately. The high TED (thromboembolytic deterrent) closed records of Resident #101 on both lower extremities. This order was could not be corrected. How the facility will identify other not present on the February 2011 signed, residents having the potential but undated, recapitulation of physician's to be affected by the same orders. deficient practice and what

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AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER:	A RIJII DING 00		00	COMPLETED	
			A. BUILDING B. WING			03/21/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
					AST MCGALLIARD ROAD		
LYND HO	DUSE			MUNCI	E, IN47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLIANCE OF		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					corrective action will be take	n?	
	The February 20	11 recapitulation (recap)			No other residents were found	to	
	_	• • • • • • • • • • • • • • • • • • • •			be affected. What measures v	vill	
		ders indicated Resident			be put into place or what		
		cian's order for "ace wrap			systemic changes will the		
	to right forearm	r/t [related to] fall pain".			facility make to ensure that the	he	
	The original date	e of this order was			deficient practice does not		
	8/11/10.				recur? The Wellness Director,		
					Residence Director, and licens		
	During on into-	iew with Resident #32 on			staff were re-trained regarding	the	
					policy for transcription on the		
		a.m., Resident #32 was			Medication Administration Rec	ora	
	up in a chair in h	ner room. The resident			and orders How will the		
	was wearing TE	D hose, but did not have			corrective action(s) will be monitored to ensure the		
	an ace wrap on h	ner right forearm.			deficient practice will not rec		
	•	licated she had not worn			i.e., what quality assurance	ui,	
		ner right arm in "months."			program will be put into plac	62	
	an acc wrap on i	ici rigiit ariii iii montiis.			The Wellness Director and/ or		
					Designee will review new orde		
		self-Administration			weekly to ensure proper		
	Assessment," da	ted 1/24/11, indicated			transcription of physician orde	rs	
	Resident #32 sel	f administered her own			on the Medication Administrati		
	medications. Th	e February 2011 recap of			Record and recaps. Findings	will	
		rs contained a section for			be reviewed and corrected		
					through our QA process as an		
		cle yes or no related to the			ongoing process. The Region	al	
	_	ole to self administer			Director of Quality and Care		
	medications. Th	is section did not contain			Management and/or Regional Director of Operations will		
	any circled respo	onse.			randomly select records to rev	iow	
					during routine site visits at least		
	A physician's or	der, dated 12/8/10,			monthly. By what date will the		
	indicated Resident #32 was to have a CMP and Lipid profile done every six months. This order was not present on				systemic changes be		
					completed? Compliance Date	e:	
					4/30/11 <b>R0349</b> , <b>R0355</b> : Will th		
					QA process for reviewing and		
	the signed Febru	ary 2011 recap of			correcting any finding contin		
	physician's order	rs.			indefinitely? If less than six		
					months, what is the criteria f	or	
	During an interv	riew on 3/16/11 at 1:30			discontinuing the reviews? 1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY  COMPLETED	
			B. WING		03/21/2011
NAME OF PROVIDER OR SUPPLIER  LYND HOUSE			2410 8	ADDRESS, CITY, STATE, ZIP CODE EAST MCGALLIARD ROAD DIE, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) E COMPLETION DATE	
IAU	p.m. with the Adinformation was physician's order being up to date  During an interv p.m., the Admini#32 no longer warm and this order the TED hose an profile needed to so the orders wornext recap.  2.) The clinical was reviewed on Diagnoses for Rebut were not lime Accident and department of the clinical record for a resingular formation of transferred to the order for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record in the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical record for transfer sent with the residual control of the clinical control of the clinical record for transfer sent with the residual control of the clinical control of th	ministrator, additional requested related to the res for February 2011 not as noted above.  iew on 3/17/11 at 1:20 strator indicated Resident ore an ace wrap on her er needed to be updated. For indicated the order for defined the CMP and lipid to be sent to the pharmacy and be included on the record for Resident #101 as 3/16/11 at 3:30 p.m. resident #101 included, atted to, Cerebral Vascular pression. The facility red this record as a "closed adent transferred to the resident being the hospital, any physician's region of any transfer form any transfer form and the resident with the as 3/16/11 at 4:10 p.m.,	IAU	random audit will be comple weekly by the Residence Director period of three months. Find will be reviewed after three months by the Residence Director to determine the need for ongo monitoring by the QA proces Findings suggestive of 100 compliance will result in no form monitoring from the Wellness Director or Designee unless otherwise deemed necessar	rector rector rector ings rector sing ss. % urther s
	additional inforn	nation was requested			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMP			(X3) DATE S		
			A. BUILDING B. WING  00  03/21/2011				
					DDDECC CITY CTATE ZINCODE	00/21/2	011
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2410 EAST MCGALLIARD ROAD				
LYND HOUSE				I	E, IN47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		ident having been	+	1710	·		DATE
	transferred to the	•					
	Review of a A "R	Resident Transfer Form,					
	dated 11/19/10, f	or Resident #101					
	indicated she had	l been transferred to the					
	•	late. The Administrator					
	The section for "Reason for Transfer" was						
		-					
	•	•					
	-						
		a fall with a fractured					
	mandible and hu	merus. The					
	Administrator in	dicated no order for					
	transfer had been	written due to the					
	resident having b	een transferred out					
	"911."						
	The clinical reco	rd lacked anv					
	information related to the resident having fallen on 11/19/10 or of being transferred to the hospital for treatment.  3.) Review of a current facility policy, dated 6/2008, provided by						
					What corrective action(s) wil	ı	04/30/2011
					-	,	
		ator, on 3/17/11 at			affected by this deficient	•	
	2:43 p.m., title	ed A. TYPES OF			practice? Resident #32's		
	•	ORDERS, included					
	but was not limited to the				Director and the order was		
	dated 11/19/10, findicated she had hospital on that did indicated this transfound in another. The section for "left blank. The Athe resident did in following the hospital records a originally been so 11/19/10 due to a mandible and hum Administrator indicates that having be "911."  The clinical recording fallen on 11/19/1 to the hospital for 3.) Review of policy, dated 6 the Administrator 2:43 p.m., title PHYSICIAN 6	for Resident #101 I been transferred to the late. The Administrator insfer form had been resident's clinical record. Reason for Transfer" was administrator indicated not return to their facility spitalization. The dicated she had obtained and the resident had ent to the hospital on a fall with a fractured merus. The dicated no order for a written due to the been transferred out  and lacked any			be accomplished for those residents found to have beer affected by this deficient practice? Resident #32's primary care physician was contacted by the Wellness		04/30/2011

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
		B. WIN			03/21/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AST MCGALLIARD ROAD		
LYND HO	DUSE				E, IN47303		
						(775)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	DATE	
IAG		ESC IDENTIFY THO INFORMATION)	+	IAG	clarified for TED hose to be	DAIL	
	following:				applied as needed. An order v	vas	
					also received for application o		
	"1. The reside	ence must have proper			the ace wrap to the right arm a		
		ders before providing			needed. The Wellness Directo	or	
					re-assessed Resident #32		
	assistance with	n any medication or			utilizing the Medication Self	.	
	treatment				Administration Assessment an deemed the resident capable		
					safe storage and administration		
	F. QUARTI	EDIV			of medications and treatments		
	`				ordered by the primary care		
	VERIFICATIO	ON OF PHYSICIAN			physician. Appropriate		
	ORDERS				documentation was completed	d on	
					the Medication Administration		
	1 Errorry 00 d	orra Dhriainian Ondan			Record and the recaps. Orde were signed appropriately. The		
	_	ays, Physician Order			closed records of Resident #1	I	
	sheets listing a	all of a resident's			could not be corrected. <b>How t</b>		
	current orders	must be signed by			facility will identify other		
	the resident's r	physician. Any			residents having the potentia	al	
	•	•			to be affected by the same		
		d/or treatment order			deficient practice and what		
	implemented,	changed and/or			corrective action will be take		
	discontinued d	luring the prior 90			No other residents were found		
		st be reflected on			be affected. What measures we be put into place or what	WIII	
					systemic changes will the		
	these orders				facility make to ensure that t	he	
					deficient practice does not		
	6. Quarterly	Physician Orders.			recur? The Wellness Director	,	
	` `	lays (or as otherwise			Residence Director, and licens	I	
		· ·			staff were re-trained regarding	the	
	indicated by state regulations), the resident's physician will sign a Treatment and Medication Order				policy for transcription on the		
					Medication Administration Rec and orders <b>How will the</b>	cora	
					corrective action(s) will be		
	form that lists				monitored to ensure the		
					deficient practice will not rec	ur,	
	medication and	d treatment orders."			i.e., what quality assurance	,	
					program will be put into place	e?	
					<u> </u>		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
			B. WING		03/21/2011
NAME OF F	ROVIDER OR SUPPLIER	}	STREET	TADDRESS, CITY, STATE, ZIP CODE	
				EAST MCGALLIARD ROAD	
LYND HO	DUSE		MUNC	CIE, IN47303	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		Ditte
				The Wellness Director and/ o	
				Designee will review new order weekly to ensure proper	ers
				transcription of physician orde	ers
				on the Medication Administrat	
				Record and recaps. Findings	will
				be reviewed and corrected	
				through our QA process as ar	
				ongoing process. The Region Director of Quality and Care	ıaı
				Management and/or Regiona	
				Director of Operations will	
				randomly select records to re-	
				during routine site visits at lea	
				monthly. By what date will the	e
				systemic changes be completed? Compliance Date	<u>.</u>
				4/30/11 <b>R0349</b> , <b>R0355</b> : Will the	
				QA process for reviewing ar	I
				correcting any finding continu	<b>I</b>
				indefinitely? If less than six	
				months, what is the criteria	
				discontinuing the reviews?	
				random audit will be complete weekly by the Residence Dire	I
				and/or the Wellness Director	
				period of three months. Findir	
				will be reviewed after three	
				months by the Residence Dire	ector
				and/or Wellness Director to	
				determine the need for ongoin	• 1
				monitoring by the QA process Findings suggestive of 100 %	
				compliance will result in no fu	
				monitoring from the Wellness	
				Director or Designee unless	
		1 1 1 - 11 1		otherwise deemed necessary	.
R0355	(h) Current clinica				
		tly, and those of discharged completed within seventy			
	(70) days of the d				
	· -	<del>-</del>			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FIRH11

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004428 If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 03/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2410 EAST MCGALLIARD ROAD LYND HOUSE MUNCIE, IN47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on record review and interview, the R0355 What corrective action(s) will 04/30/2011 be accomplished for those facility failed to ensure closed clinical residents found to have been records were completed and in order affected by this deficient within 70 days of the discharge date for 1 **practice?** The record of Resident of 2 closed clinical records reviewed in a #101 is now closed. How the sample of 9. (Resident #101) facility will identify other residents having the potential to be affected by the same Findings include: deficient practice and what corrective actions will be 1.) The clinical record for Resident #101 taken? No other residents found was reviewed on 3/16/11 at 3:30 p.m. to be affected. What measures will be put into place or what Diagnoses for Resident #101 included, systematic changes will the but were not limited to, Cerebral Vascular facility to ensure that the Accident and depression. The facility deficient practice does not staff had identified this record as a "closed recur? The Wellness Director record" for a resident transferred to the and Residence Director were re-trained to the policy and hospital. procedure concerning closed clinical records. The Wellness During an interview on 3/21/11 at 8:43 Director and/or Designee will a.m., the Administrator indicated Resident review closed records to ensure continued compliance with our #101 had been transferred to the hospital policy and procedure concerning on 11/19/10 and did not return to the closed clinical records. How will facility following her hospitalization. The the corrective action(s) will be Administrator indicated she had located monitored to ensure the the 11/19/10 transfer form in another deficient practice will not recur, i.e., what quality assurance resident's clinical record. program will be put into place? The Wellness Director and/or The resident's clinical record was in three Designee will monitor resident separate folders and was not in any type records for discharged residents are closed within 70 days and are of chronological and/or orderly manner. organized and a complete. The record was missing drug disposition Findings will be reviewed and information for four medications noted on corrected through the QA process the November signed recapitulation of as an ongoing process. By what date will the systemic changes physician's orders.

Facility ID:

PRINTED: 04/29/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co A. BUILDING B. WING	00	COMPLE 03/21/20	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2410 EAST MCGALLIARD ROAD  MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	a.m., the Admini the one who clos records when res She indicated she	iew on 3/21/11 at 10:30 strator indicated she was ed out the clinical idents were discharged. e was not always able to a timely manner.		be completed? Compliand Date: April 30 2011 R0349, R0355: Will the QA process reviewing and correcting finding continue indefinite if less than six months, we the criteria for discontinue the reviews? A random audice completed weekly by the Residence Director and/or Wellness Director for a per three months. Findings will reviewed after three months the Residence Director and Wellness Director to determ the need for ongoing monit by the QA process. Finding suggestive of 100 % comp will result in no further mon from the Wellness Director Designee unless otherwised deemed necessary.	ss for any ely? that is ing dit will e the iod of be is by d/or mine toring gs bliance iitoring or		